emailed validation letter 11/1/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10-10-11
Amount $1500-
Ck # 16528940

RECEIVED
OCT 10 2011
OFFICE OF INSPECTOR GENERAL

I. IDENTIFICATION

Name: Glasgow State Nursing Facility

Address: 199 State Avenue, P. O. Box 189

City/County/Zip: Glasgow, Barren, KY 42141

Telephone number: 270-651-2151 Ext. 2130 Rebecca.Tandy@ky.gov

Administrator: Rebecca Tandy

Date facility operation began at current address: 7-1-77

Date facility began operation under current owner: 7-1-77

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	100	100
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	xxx	Profit	Individual
County		Nonprofit	Partnership
City			Corporation
Private			

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Commonwealth of Kentucky, Cabinet for Health and Family Services; Dept. for Behavioral Health, Developmental and Intellectual Disabilities, 275 East Main Street, Frankfort, KY 40621

(OVER)

10/31

If facility owned or leased by a corporation, complete the following:

Name of corporation N/A

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
N/A	

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Rebecca Tomaly — Signature of authorized representative

Administrator — Title

10/6/11 — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)